

(i) NO DEFERENCE TO PRIOR DETERMINATIONS.—In making determinations under subparagraph (A), there shall be no deference given to determinations made by the plan or issuer or the recommendation of a treating health care professional (if any).

(ii) USE OF APPROPRIATE PERSONNEL.—A qualified external review entity shall use appropriately qualified personnel to make determinations under this section.

(C) NOTICES AND GENERAL TIMELINES FOR DETERMINATION.—

(i) NOTICE IN CASE OF DENIAL OF REFERRAL.—If the entity under this paragraph does not make a referral to an independent medical reviewer, the entity shall provide notice to the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) filing the request, and the treating health care professional (if any) that the denial is not subject to independent medical review. Such notice—

(I) shall be written (and, in addition, may be provided orally) in a manner calculated to be understood by a participant or enrollee;

(II) shall include the reasons for the determination;

(III) include any relevant terms and conditions of the plan or coverage; and

(IV) include a description of any further recourse available to the individual.

(ii) GENERAL TIMELINE FOR DETERMINATIONS.—Upon receipt of information under paragraph (2), the qualified external review entity, and if required the independent medical reviewer, shall make a determination within the overall timeline that is applicable to the case under review as described in subsection (e), except that if the entity determines that a referral to an independent medical reviewer is not required, the entity shall provide notice of such determination to the participant, beneficiary, or enrollee (or authorized representative) within such timeline and within 2 days of the date of such determination.

(d) INDEPENDENT MEDICAL REVIEW.—

(1) IN GENERAL.—If a qualified external review entity determines under subsection (c) that a denial of a claim for benefits is eligible for independent medical review, the entity shall refer the denial involved to an independent medical reviewer for the conduct of an independent medical review under this subsection.

(2) MEDICALLY REVIEWABLE DECISIONS.—A denial of a claim for benefits is eligible for independent medical review if the benefit for the item or service for which the claim is made would be a covered benefit under the terms and conditions of the plan or coverage but for one (or more) of the following determinations:

(A) DENIALS BASED ON MEDICAL NECESSITY AND APPROPRIATENESS.—A determination that the item or service is not covered because it is not medically necessary and appropriate or based on the application of substantially equivalent terms.

(B) DENIALS BASED ON EXPERIMENTAL OR INVESTIGATIONAL TREATMENT.—A determination that the item or service is not covered because it is experimental or investigational or based on the application of substantially equivalent terms.

(C) DENIALS OTHERWISE BASED ON AN EVALUATION OF MEDICAL FACTS.—A determination that the item or service or condition is not covered based on grounds that require an evaluation of the medical facts by a health care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition.

(3) INDEPENDENT MEDICAL REVIEW DETERMINATION.—

(A) IN GENERAL.—An independent medical reviewer under this section shall make a new

independent determination with respect to whether or not the denial of a claim for a benefit that is the subject of the review should be upheld, reversed, or modified.

(B) STANDARD FOR DETERMINATION.—The independent medical reviewer's determination relating to the medical necessity and appropriateness, or the experimental or investigational nature, or the evaluation of the medical facts, of the item, service, or condition involved shall be based on the medical condition of the participant, beneficiary, or enrollee (including the medical records of the participant, beneficiary, or enrollee) and valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert opinion.

(C) NO COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage, provide coverage for items or services for which benefits are specifically excluded or expressly limited under the plan or coverage in the plain language of the plan document (and which are disclosed under section 121(b)(1)(C)). Notwithstanding any other provision of this Act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined (in the plain language of the plan or coverage documents) under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage and that is disclosed under section 121(b)(1) shall be considered to govern the scope of the benefits that may be required: *Provided*, That the terms and conditions of the plan or coverage relating to such an exclusion or limit are in compliance with the requirements of law.

(D) EVIDENCE AND INFORMATION TO BE USED IN MEDICAL REVIEWS.—In making a determination under this subsection, the independent medical reviewer shall also consider appropriate and available evidence and information, including the following:

(i) The determination made by the plan or issuer with respect to the claim upon internal review and the evidence, guidelines, or rationale used by the plan or issuer in reaching such determination.

(ii) The recommendation of the treating health care professional and the evidence, guidelines, and rationale used by the treating health care professional in reaching such recommendation.

(iii) Additional relevant evidence or information obtained by the reviewer or submitted by the plan, issuer, participant, beneficiary, or enrollee (or an authorized representative), or treating health care professional.

(iv) The plan or coverage document.

(E) INDEPENDENT DETERMINATION.—In making determinations under this section, a qualified external review entity and an independent medical reviewer shall—

(i) consider the claim under review without deference to the determinations made by the plan or issuer or the recommendation of the treating health care professional (if any); and

(ii) consider, but not be bound by, the definition used by the plan or issuer of “medically necessary and appropriate”, or “experimental or investigational”, or other substantially equivalent terms that are used by the plan or issuer to describe medical necessity and appropriateness or experimental or investigational nature of the treatment.

(F) DETERMINATION OF INDEPENDENT MEDICAL REVIEWER.—An independent medical reviewer shall, in accordance with the dead-

lines described in subsection (e), prepare a written determination to uphold, reverse, or modify the denial under review. Such written determination shall include—

(i) the determination of the reviewer;

(ii) the specific reasons of the reviewer for such determination, including a summary of the clinical or scientific evidence used in making the determination; and

(iii) with respect to a determination to reverse or modify the denial under review, a timeframe within which the plan or issuer must comply with such determination.

(G) NONBINDING NATURE OF ADDITIONAL RECOMMENDATIONS.—In addition to the determination under subparagraph (F), the reviewer may provide the plan or issuer and the treating health care professional with additional recommendations in connection with such a determination, but any such recommendations shall not affect (or be treated as part of) the determination and shall not be binding on the plan or issuer.

(e) TIMELINES AND NOTIFICATIONS.—

(1) TIMELINES FOR INDEPENDENT MEDICAL REVIEW.—

(A) PRIOR AUTHORIZATION DETERMINATION.—

(i) IN GENERAL.—The independent medical reviewer (or reviewers) shall make a determination on a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days after the date of receipt of information under subsection (c)(2) if the review involves a prior authorization of items or services and in no case later than 21 days after the date the request for external review is received.

(ii) EXPEDITED DETERMINATION.—Notwithstanding clause (i) and subject to clause (iii), the independent medical reviewer (or reviewers) shall make an expedited determination on a denial of a claim for benefits described in clause (i), when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination, and a health care professional certifies, with the request, that a determination under the timeline described in clause (i) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request for external review is received by the qualified external review entity.

(iii) ONGOING CARE DETERMINATION.—Notwithstanding clause (i), in the case of a review described in such clause that involves a termination or reduction of care, the notice of the determination shall be completed not later than 24 hours after the time the request for external review is received by the qualified external review entity and before the end of the approved period of care.

(B) RETROSPECTIVE DETERMINATION.—The independent medical reviewer (or reviewers) shall complete a review in the case of a retrospective determination on an appeal of a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) in no case later than 30 days after the date of receipt of information under subsection (c)(2) and in no case later than 60 days after the date the request for external review is received by the qualified external review entity.

(2) NOTIFICATION OF DETERMINATION.—The external review entity shall ensure that the plan or issuer, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if